Plan for the Closure of Dorothea Dix Hospital

Presented to:

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And
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Outline of Contents

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This report, the *Plan for the Closure of Dorothea Dix Hospital*, will describe steps the Department of Health and Human Services (DHHS) will take to formally close Dorothea Dix Hospital (DDH) through the relocation of a 30-bed Forensic Minimum Security Unit, the only remaining inpatient psychiatric beds and service to be provided at the hospital.

Additionally, this report will outline earlier cost reduction measures implemented at DDH to minimize the impact of a projected budget deficit and will discuss other issues related to the closure of Dorothea Dix Hospital.

I. Cost Reduction Measures at Dorothea Dix Hospital To Be Completed by December 31, 2010

During Fiscal Year 2010-2011, Dorothea Dix Hospital is projected to operate at a budget deficit of $28,950,638. In recent years when the hospital had some State appropriations and operated at a smaller deficit, funding from community mental health services and other DHHS Divisions has been used to make up the deficits. As discussed during the past legislative session with legislative leadership, additional budget reductions of over $13 million in funds previously used to operate DDH, combined with additional budget reductions for the Department as a whole, made it virtually impossible for DHHS to continue past operations of DDH without further reallocation of funds currently allocated to sustain community mental health services. To realize a reduction in the current operating deficit at DDH, cost reduction measures are currently being implemented. The majority of patient services will be transferred to Central Regional Hospital (CRH) in Butner and Cherry Hospital in Goldsboro. Three patient service units will remain open on the Dix Campus under the administrative and operational oversight of CRH. The cost reduction measures currently being implemented at DDH are projected to reduce the budget deficit by $16.9M through reductions in administrative and other indirect expenses and include:

- Transfer to Central Regional Hospital
  - 60 Adult Admission Beds (Dec. 2010)
  - 11 Adult Long Term Beds (Sept. 2010)
  - 54 Forensic Medium/Maximum and Pre-Trial Beds (Dec. 2010)
- Transfer to Cherry Hospital
  - 30 Adult Long Term Beds (Oct./Nov. 2010)
- Remaining on Dix Campus
  - 30 Forensic Minimum Beds
  - Child Outpatient Program
  - Clinical Research Outpatient Unit

No Reduction in Bed Capacity. These cost reduction measures will result in no reduction in bed capacity in the system. All adult admission beds currently at DDH will be transferred to CRH, with Wake and Sandhills LMEs referring all

patients to CRH. Forensic beds will also be relocated. As identified above, 11 patients in the adult long term unit at DDH have been transferred to CRH and the CRH adult long term unit (called the community transition unit), has been increased by 11 beds.

Cherry Hospital will increase their current census by 30 beds on their adult long term unit, including 24 patients currently on the adult long term unit at DDH. These 30 beds are not "new" to the system. They have been non-operational for more than 2 years. By bringing 30 beds back on-line at Cherry, the system is effectively replacing beds from DDH with beds at Cherry. Additionally, this allows Cherry to increase their capacity using existing resources, further reducing the deficit in the Division of State Operated Facilities (DSOHF) system.

Clinical Research Unit Changes. At the request of the University of North Carolina Department of Psychiatry, changes were made to the Clinical Research Unit (CRU) model. Due in part to an increase in acuity of patients on the admissions unit who do not meet criteria for the CRU clinical protocols, it was determined that the outpatient component of the CRU would be expanded and the inpatient beds would be eliminated. To maintain access to the greatest number of individuals participating in outpatient clinical research, it was agreed that the unit would remain on the Dix Campus rather than relocating to Butner as previously planned.

Timeline for Implementation of Cost Reduction Measures. As of the writing of this report, late October, 2010, the cost reduction measures are in the process of being implemented. The patients from the adult long term unit at DDH have been transferred to CRH. The remaining patients on the adult-long term unit at DDH are currently transferring to Cherry Hospital, with a small number transferring each week until all have moved by mid-November.

In early December, admissions to the Inpatient Pre-Trial Evaluation Unit will be discontinued at DDH. Evaluations on any current individuals on the unit will be completed. The majority of pre-trial evaluations, 80-85%, are conducted on an outpatient basis. Outpatient evaluations will continue during the transition period.

During December, the Forensic Maximum and Medium and Pre-Trial Evaluation Units will be transferred to CRH. Inpatient Pre-Trial Evaluations will resume at CRH. The Adult Admissions Unit will also transfer from DDH to CRH during December. Admissions from Wake and Sandhills LMEs to the Adult Admissions Unit will cease at DDH and begin at CRH in early December. Individuals on the Adult Admissions Unit at DDH will continue to be served for approximately 2 weeks. Since the average length of stay on the unit is less than 2 weeks, it is anticipated that the majority of patients will be discharged during that time. Individuals remaining on the unit will be transferred to CRH.

Preparing Patients for Transition. Patients transferring to CRH or Cherry Hospital from DDH during the implementation of cost reduction measures have been prepared for the move in a variety of ways. Patients, their families and/or guardians and representatives from their LMEs have or will be notified of upcoming moves. Disability Rights North Carolina (DRNC) has also been notified and invited to attend person-centered treatment and transition planning

meetings related to the moves. Staff members from the receiving hospitals have met with patients and their families/guardians to begin to develop relationships, describe the facilities to which they were being transferred and answer any questions. Individuals transferring to Cherry Hospital and their families were offered the opportunity to visit Cherry prior to the move. Additionally, a group of patients from long-term units at DDH visited CRH to tour the facility and to ask questions about their relocation with the goal of sharing the experience with those not able to visit.

Staff Considerations During Transition. Dorothea Dix Hospital has a long and proud history of quality care and treatment for individuals served. This quality is due to the staff at DDH. Although cost reduction measures have been necessary due to the budget deficit, DHHS has implemented mechanisms to ensure that as many DDH employees as possible have job opportunities within the system of State-operated facilities. These mechanisms include:

1. Ninety-nine percent of DDH employees have been offered positions at CRH to ensure that there is sufficient staffing at CRH. As natural staff turnover occurs, some of these positions will not be replaced. This level of staffing during the cost reduction measures accomplishes 3 significant goals: 1) protecting employee jobs, 2) allowing for extra staffing during the transition, a time when additional support is needed for the patients, and 3) reducing costly recruitment and hiring for CRH.
2. The Division of State Operated Healthcare Facilities has established a hiring priority for DDH employees for any vacancies occurring at other DSOHF facilities. Some DDH employees are not able to commute to Butner; therefore, employment in facilities located in other areas is preferable.
3. Cherry Hospital has facilitated the hiring of DDH employees, typically those living east or south of Raleigh, who are not able to commute to Butner, but want to continue working in a psychiatric hospital.

These measures have been implemented to assist current DDH employees; however, they will also enhance quality staffing at other DSOHF facilities.

II. Formal Closure of Dorothea Dix Hospital

Once all statutory requirements have been met, and necessary preparations have been accomplished at CRH, the Forensic Minimum Unit will be transferred to CRH, eliminating all inpatient beds at the current DDH and formally closing all hospital operations. The specific timeline for this transfer has not been established. Until such transfer and closure is accomplished, the Forensic Minimum Unit will be managed by CRH. The Forensic Minimum Unit has remained strongly linked to the other Units on the Forensic Treatment Unit (FTU), Forensic Maximum and Forensic Medium, as well as, Pre-Trial Evaluation. These services are operated as one service unit with consistent philosophy, policies and practices. The co-location of all units of the FTU will enhance the ability of FTU staff to consistently manage the service unit.

How Patients Will Be Cared For After Closure

Ensuring Comparable Care and Treatment after Transfer to CRH. The overall goal of the Forensic Treatment Unit (FTU) is to provide psychiatric care and treatment to individuals who have been admitted due to a finding of Not Guilty by Reason of Insanity (NGRI) or who have been found Incapable to Proceed to Trial (ITP). As individuals on the FTU demonstrate increased psychiatric stability and the ability to observe established rules, they progress to forensic units with less security. As the individual is clinically able, the clinical focus becomes assisting the individual to reintegrate into the community. With clinical recommendation, the Court may grant individuals, typically on the Forensic Minimum Unit, increased privileges such as freedom to independently come and go from the unit, grounds or community passes for specific lengths of time and facility based or community based work privileges. This progression of increasing independence prepares the individual for success to the point that the Court orders that s/he be discharged. The philosophy and programming that prepares individuals in the Forensic Minimum Unit for community integration will continue when DDH closes and the Forensic Minimum Unit relocates to Butner.

Treatment. Currently, patients in the Forensic Minimum Unit receive treatment, education, skills training and support by participating in the treatment mall. For reference, the following brief description of a treatment mall is provided. A primary objective of the treatment mall is to make the hospital's full complement of treatment and rehabilitation services accessible to all patients. All on-unit functions, including medication administration, medical services, and meals, are transferred to the mall during its operating hours. On the treatment mall, group facilitation is provided by practitioners from various hospital clinical disciplines, such as rehabilitation services, nursing, psychology, and social work. The treatment mall provides physical and social environs in which participants are more likely to become actively engaged in rehabilitation and recovery than they would be in unit-based programs. After transfer to CRH, patients on the Forensic Minimum Unit will participate in the treatment mall located at CRH and will receive education, skills training and support services comparable to the services they received at DDH.

Employment. Currently, 4 of the approximately 30 patients on the Forensic Minimum Unit work in the community: two at the Raleigh Convention Center,

one at a service station and one at a large retailer. Other forensic minimum patients currently work on the DDH campus in the following areas: food service, library services, janitorial services and landscaping services. After transfer to CRH, the individuals currently working in the community will be able to seek comparable jobs in Butner, Creedmoor (approximately seven miles from Butner) and Durham (approximately 15 miles from Butner). Patients seeking jobs close to Butner will be able to contact, with the assistance of vocational specialists at CRH, the approximately eight convenience stores/gas stations and approximately 25 restaurants located within five miles of Butner and the large retailers located approximately 10 miles from Butner in northern Durham. CRH has several vans and will ensure that staff is available to transport Forensic Minimum patients to their job sites, as needed. The patients currently working on the DDH campus will be able to do comparable work at CRH since the same jobs available on the DDH campus will be available on the CRH campus. Examples of CRH campus jobs include, but are not limited to: working in the Grill (restaurant-like setting which employs patients), cleaning up break room tables, helping the audio-visual team, landscaping, helping Nutrition Services, window-washing, washing State vehicles, library work, newspaper and mail delivery, helping Volunteer Services, carpentry shop work, and helping in the linen room.

Socialization. Currently, the treatment plans for some clinically stable patients in the Forensic Minimum Unit allow them to leave and enter DDH at will and to walk unaccompanied on the hospital grounds. Additionally, when allowed by their treatment plan, Forensic Minimum patients are taken by staff on outings to libraries, churches, sporting events, restaurants, malls, cultural and educational events. After transfer to CRH, the individuals in the Forensic Minimum Unit will be housed on the former John Umstead Hospital campus and their housing unit will be configured to allow them the same hospital entry and exit privileges that they currently have at DDH. The Butner/Creedmoor/Durham/Chapel Hill area offers many cultural, leisure, spiritual and educational activities. Examples of places near CRH that provide cultural/leisure activities include, but are not limited to, libraries in Creedmoor, Durham and Chapel Hill; bowling alleys in Bahama and northern Durham; museums in Durham and Chapel Hill; movie theatres in Durham and Chapel Hill; State recreation areas; the Durham Bulls Athletic Park; and shopping malls in Durham and Chapel Hill. Additionally, 12 places of worship are located in the Butner/Creedmoor area and many more are located in the Durham/Chapel Hill area. Also, located near CRH are two community colleges, Vance-Granville Community College and Durham Technical Community College. Other schools near CRH are Duke University and North Carolina Central University located in Durham and the University of North Carolina at Chapel Hill. As noted in the Employment section of this report, CRH has several vans and will ensure that staff is available to transport patients on the Forensic Minimum Unit, as allowed by their treatment plans, to cultural, leisure, spiritual and educational activities.

<u>Central Regional Hospital Bed Capacity.</u> Once all patients on the Forensic Minimum Unit and those in the earlier cost reduction measures have transferred to CRH, the total bed capacity at CRH will be 396 beds.

CRH Bed Complement after Closure of DDH

Service	Number of Beds
Adult Admissions	140
Community Transitions (adult long term)	76
Geriatric Services Unit	32
Medical Services Unit	18
Forensic/Pre-Trial Services Unit	84
Child/Adolescent Services Unit	34
Special Population, under development (previously - inpatient CRU)	12
Total	396

As discussed previously, Cherry Hospital will bring back on-line 30 beds on the adult long term unit, including the transfer of 24 individuals from DDH as part of the cost reduction measures. The remaining 6 beds will serve patients from Cherry's Adult Admission Unit.

How Support Services to Community-Based Agencies and Outreach Services Will Be Continued

Ensuring that a System is in Place for the Continuation of Hearings for Patients in the Forensic Minimum Unit. All patients in the FTU, including those in the Forensic Minimum Unit, have specific legal requirements due to their forensic status. Planning for the transfer of patients in the FTU includes ensuring that court hearings and necessary supports such as transportation are arranged. Individuals in the Forensic Minimum Unit have either been found Not Guilty by Reason of Insanity (NGRI) or Incapable to Proceed to Trial (ITP). All NGRI hearings, including those for Forensic Minimum, are held in the county where the facility is located or the court where the criminal case was originally tried. There are currently two patients in Forensic Minimum who have their NGRI hearings in the county where they were criminally tried. The others have their NGRI hearings in Wake County.

An adjudication of NGRI by the criminal court results in an automatic commitment to a State hospital. The patient must have the first hearing on the automatic NGRI commitment within 50 days. At the first hearing, the court can commit the patient for a maximum of 90 days. Before that commitment expires, another hearing must be held to determine if the patient still meets NGRI commitment criteria. At this second hearing, the court can commit the patient for a maximum of 180 days. Thereafter, at all subsequent NGRI hearings, the court can commit up to 365 days.

The Clerk of Court coordinates the calendar with the designated person at the facility and the Attorney General's Office, which coordinates with the lawyers who represent the patients. Individuals can waive their court appearance and consent to the commitment recommendation or they can have a hearing. Doctors, social workers, psychologists, and other members of the treatment team are sometimes needed to testify in court.

Patients who were adjudicated NGRI in Superior Court have their re-hearings in Superior Court. Patients who were adjudicated NGRI in District Court have their

re-hearings in District Court. Superior Court Cases at DDH for those that are NGRI, are held in the Wake County Courthouse. NGRI re-hearings are conducted at District Court which is held on hospital grounds.

There are five patients in Forensic Minimum who are not NGRI acquittees; they are patients with serious charges but who have been found Incapable to Proceed (ITP) on those charges. Patients with ITP status are held on civil commitments and have the same District Court hearings as all other committed patients. These hearings will continue to be held on Dix Campus while the Forensic Minimum Unit is located there. Upon closure, the few remaining patients who have ITP status will transfer to CRH and their hearings will be conducted at CRH.

Except for the NGRI cases that are tried in the counties where the original criminal trial occurred, Superior Court Cases for those patients that are Not Guilty By Reason of Insanity after the transfer will be held in Granville County. They schedule one Superior Court session per month and the court system is responsible for appointing a judge for that district.

As mentioned above, patients that are Incapable to Proceed will have already integrated into the court system at Central Regional Hospital prior to the Forensic Minimum transfer from DDH.

Child Outpatient and Outpatient Clinical Research Units. Both the Child Outpatient and Clinical Research Outpatient Units will continue to be located on the Dix Campus after the Forensic Minimum Unit transfers to Butner. Central Regional Hospital will operate these programs in conjunction with the University of North Carolina, Department of Psychiatry, and will maintain operational and administrative oversight. Both Units are located in the Scott Building on Dix Campus and will continue to operate from this location indefinitely. The University of North Carolina, Department of Psychiatry has been actively involved with the planning for these units.

Impact on the Remaining State Facilities

The impact on other State facilities will be limited to CRH. Since the Forensic Minimum Unit has been located on the Dix Campus, but under the administrative and operational oversight of CRH, the impact will be limited to services being in closer proximity to FTU and hospital management. This is viewed positively by FTU and hospital management.

Although minimal, some positions have been reassigned to the Forensic Minimum Unit while located on Dix Campus since the unit did not have the infrastructure of co-located service units. For example, the Unit will require re-deployed staff to provide active treatment since there will not be an existing functional treatment mall available for the patients on the Forensic Minimum Unit when they are the only patients remaining on Dix Campus. These positions will return to CRH service areas that need additional staff or to replace contracted staff.

No impact from the relocation of Forensic Minimum is anticipated for any other State operated facilities.

III. Additional Issues Related to the Closure of Dorothea Dix Hospital

Community Linkages

The closing of DDH, through transferring Forensic Minimum services to CRH, plus the earlier cost reduction measures, will not result in a reduction in capacity to the system. In fact, with the addition of an Adult Admissions unit at Broughton Hospital, there will actually be a small increase in the number of available beds in the system. Even though there is no reduction in bed capacity, community linkage is still a critical issue for individuals being discharged from State hospitals. The issues related to community linkages will not change as a result of the closure of DDH or the earlier cost reduction measures. Below is a brief discussion of mechanisms and processes related to community linkages.

Admission Delays. Limited resources, both in psychiatric units in community hospitals and in State hospitals, have led to delays for individuals requiring inpatient admission. Currently, the State hospitals are consistently on delay for admissions. The average wait time for patients in community emergency departments referred to State hospitals ranges from approximately 46 hours at Cherry Hospital to over 95 hours at Broughton Hospital. Although 60 adult admission beds have transferred from DDH to CRH, the total number of admission beds remains the same. Without a reduction in the number of admission beds in the system, no negative impact upon admission delays is anticipated. Additionally, Broughton Hospital is currently planning the expansion of its adult admission unit by 19 beds. This will reduce admission delays in the Western Region.

Daily Admission and Discharge Reports. Each State hospital provides an LME-specific report on a daily basis listing individuals from the LME catchment area who have been admitted or discharged. Each report contains basic information including the patient's name, age, and home county. Additionally, each hospital has opted to include additional information based on the discussions with LMEs in their region. The reports meet current confidentiality and privacy requirements.

Hospital Liaisons. Each LME has one or more employees identified as their LME Liaison to the State hospital. The Hospital Liaison ensures that the LME and providers are working in conjunction with the hospital during an individual's inpatient hospitalization. The Liaison is intended to be, and in most cases is, on site at the hospital, directly communicating with the patient and the treatment team. The Liaison typically attends treatment planning meetings and assists with discharge planning by assisting with appointments and/or connecting with community providers to engage in discharge planning. The Liaison proves to be critical when the development and/or implementation of a discharge plan is difficult or complicated. For example, the Liaison is the critical link to the LME, if funding or services need to be braided to meet the unique needs of the individual.

Discharge Communication. To increase the quality and consistency of discharge information provided to the patient, the LME and providers upon discharge, DSOHF worked with community stakeholders and State hospital staff to develop the Continuing Care Plan (CCP). The person-centered CCP is sent to the involved parties at the time of discharge and replaces the previous aftercare plans. The CCP includes the following information:

- Basic patient information
- Outpatient appointments with dates, contact names, addresses, telephone numbers and purpose of appointment
- Psychosocial needs and recommendations for treatment approach
- Service recommendations
- Medical diagnoses, follow-up recommendations and education
- Patient Recovery Plan
- Diagnostic information and reason for admission
- Discharge medication information, and
- Signatures of individuals involved in the development of the CCP.

The CCP is intended to ensure that the LME and, most critically, all aftercare providers have the necessary information from the hospital to begin immediate assessment and treatment of the individual in the community.

All hospitals currently complete the CCP together with each patient that is discharged. Subsequently, there will be no change in this process due to the transfer of patients to CRH or Cherry Hospital.

Discharge to Homeless Shelters. The DHHS, DSOHF and the State hospitals have taken measures to reduce the number and percentage of individuals discharged to homeless shelters. In FY2009, all DSOHF facilities entered into agreements with their local HUD Continuums of Care that stated the facilities would not discharge patients to homeless shelters if they had not been admitted from homeless conditions or had been in the facility for greater than 30 days. These agreements were based on federal templates for facilities nation-wide that regularly discharge individuals to homeless shelters including jails, prisons, foster care, hospitals, etc.

Since the agreements have been signed, all State hospitals have followed the stipulated conditions. Rarely is a patient that does not meet the above criteria discharged to a homeless shelter. Approval by DSOHF is required before a patient is discharged to a homeless shelter if s/he was not homeless upon admission or has been hospitalized for more than 30 days. DSOHF staff review the case with the hospital social worker to ensure that all alternative placements have been pursued.

During FY09-10, less than 5% of all discharges, or a total of 342 individuals, were discharged from State hospitals to homeless shelters. By individual report, approximately 8% of all admissions were living in homeless situations; typically a homeless shelter or the streets, immediately prior to admission.

Discharges to Homeless Shelters, All Hospitals

	FY07-08	FY08-09	FY09-10
Total Discharged to Homeless Shelters, All State Hospitals	1070	493	342
Percent of Total Discharges	7.11%	4.75%	4.70%

Data extracted from the Healthcare Enterprise Accounts Retrievable Tracking System (HEARTS).

The closure of DDH and the earlier cost reduction measures are not expected to positively or negatively impact the percentage of individuals discharged to homeless shelters. Central Regional Hospital and Cherry Hospital social workers will continue to abide by the on-going HUD agreements. Liaisons will also continue to work with hospital staff, at CRH and Cherry rather than DDH, to identify and arrange appropriate discharge placements.

Community Services and Qualified Providers

Wake Human Services and Sandhills Center are the Local Management Entities (LMEs) which are affected by the DDH closure, the earlier cost reduction measures and the transfer of individuals served at DDH to CRH. Other catchment areas previously served by DDH have been redrawn to be served by Broughton Hospital or Cherry Hospital; only Wake and Sandhills directly served by DDH.

If community-based services are available for persons with mental health and/substance abuse needs at any point on the continuum of need, it is less likely that the individual will require intervention in a State facility such as CRH, or a facility for treating persons with substance use issues. Following are those services and supports established by the two LMEs to address the needs of persons who reside within their catchment areas, and who had been served by DDH, and are now ultimately served, when necessary, at CRH.

Sandhills Center Community Services. Sandhills Center, through its partnership and collaboration with consumers, families, providers, advocacy groups, state and community agencies and initiatives, participates in the provision of the following community service options. These options include crisis prevention, intervention and stabilization; step-down and diversion services; and ongoing treatment, support, and recovery activities.

- Hospital Liaison Services – 3 Liaisons
- Hospital Transition Team – 1 Team
- Mobile Crisis Services – 2 Teams
- Daytime Crisis Walk-in Services – 9 Clinics
- Assertive Community Treatment – 9 Teams
- Targeted Case Management – 19 providers
- Psychosocial Rehabilitation – 23 locations
- Community Support Team – 50 Providers

- Substance Abuse Intensive Outpatient – 18 Providers
- Intensive In-Home – 70 Providers
- Day Treatment – 27 Providers
- Multi-Systemic Therapy – 5 providers
- Residential Crisis Bed/Respite Services – 16 Beds
- Contracted Local Hospital Beds Available – 9 Beds
- Local Inpatient and Detoxifications Services – 7 Locations
- After-hours face to face assessment services – 3 Providers
- Local Emergency Room Evaluations
- Facility Based Crisis – 1 Provider
- Individual Consumer Support
- Crisis Intervention Training for Law Enforcement – 6 Law Enforcement Agencies

Sandhills Center Crisis Service Expenditures. The crisis intervention and crisis services identified above are critical to meeting the needs of individuals with mental health, intellectual/developmental or substance use issues prior to the need to seek intervention in the State Hospital Facility. The availability and provision of appropriate crisis services is important in order to ensure that the state hospitals are used only for those consumers whose needs can not be met locally. When the designation, "Non-UCR" is included, this means the service was reported without identifying the number of units provided. The number of units would tell us the number of individuals served. In such cases, only the amount expended for the service is reported. For Sandhills Center, the expenditures reported over the previous two (2) Fiscal years (FYs) are:

Sandhills:
FY 2009

Service	Persons Served	Billing Code	Expenditure
Crisis Intervention	43	H2011	$42,309
Mobile Crisis Team		Non-UCR	$200,000
Walk-In Crisis		Non-UCR	$110,000
Facility Based Crisis	108	YP485	$114,710

Sandhills:
FY 2010

Service	Persons Served	Billing Code	Expenditure
Crisis Intervention	471	H2011	$277,881
Mobile Crisis Team		Non-UCR	$372,803
Facility Based Crisis	57	YP485	$56,363

Wake Human Services Community Services
The Services, availability and options, for Wake LME are listed below:

- Community Support Child – 29 providers (this service will end January 1, 2011, except for those individuals who are allowed to receive it through EPSDT
- Community Support Adult – 23 Providers (this service will end January 1, 2011)
- Community Support Team – 32 Providers
- Diagnostic Assessment – 31 providers
- Mobile Crisis Team – 1 Team
- Intensive In-Home -- 37 Providers
- Multi-Systemic Therapy – 3 Providers
- Assertive Community Treatment Team – 4 Providers
- Psychosocial Rehabilitation – 5 Providers
- Substance Abuse Comprehensive Outpatient Treatment – 5 Providers
- DD Targeted Case Management – 26 Providers
- Child Day Treatment – 10 Providers
- Substance Abuse Intensive Outpatient Treatment – 9 Providers
- Opioid Treatment --1
- Community Alternatives Program -- 43 Providers
- Level III Residential for Children --14 Providers (25 facilities in Wake Co.)

Of these services listed above, two (2) are nationally identified as evidence-based practices: Multi-Systemic Services (MST) and Assertive Community Treatment Teams (ACTT). ACTT is a service overseen by a Psychiatrist and is considered the most intensive community-based service available. It is used as a step-down service from the hospital setting, or a service which, if successfully provided, limits or prevents hospital stays for individuals with substance use or mental health issues.

Residential Services for children (Level III) also serve as step-down from inpatient settings; or when appropriately provided, prevention or limitation of inpatient stays.

Wake Human Services Crisis Services Expenditures. For Wake Human Services, the expenditures reported over the previous two (2) Fiscal years (FYs) are:

Wake Human Services
FY 2009

Service	Persons Served	Billing Code	Expenditure
Mobile Crisis Team		Non-UCR	$267,199
Facility Based Crisis	562	YP485	$1,505,993

Wake Human Services
FY 2010

Service	Persons Served	Billing Code	Expenditure
Mobile Crisis Team		Non-UCR	$170,582
Crisis Intervention	21	H2011	$722
Adult Crisis Services		Non-UCR	$96,464
Child MH/DD/SA Crisis Services		Non-UCR	$8,430
Walk-In Crisis/Psychiatric Aftercare		Non-UCR	$59,494
Facility Based Crisis	445	YP485	$1,197,194

Additional Crisis Facility Options:
Wake Crisis Assessment Unit: (Wakebrook Campus). The Wake Crisis Assessment Unit will open January 2011, and will house the following Crisis Service Options for persons with mental health, intellectual/developmental or substance use crisis issues:

- 24/7 Crisis Assessment Services
- Wake Transition Team
- Sixteen (16) Short-Stay residential Crisis Beds
- Sixteen (16) Non-Hospital Medical Detoxification Beds
- One (1) Dually Licensed Unit of sixteen (16) beds to open March, 2011, and a second one later in 2011.
- After six (6) months of operation, certification for Involuntary Commitment will be sought.
- LME interface with the hospital to help facilitate discharge to appropriate placements.
- One FTE LME Care Coordination hospital liaison will cover all adult admission, long term and forensic units at CRH once DDH closes. The liaison will be on-site 20 hours per week (50%) and at other times at the LME office or traveling. Another 0.25 FTE will cover the geriatric unit and the RJ Blackley ADATC, once that person is hired. There are also two (2) full-time staff assigned to Holly Hill Hospital
- In March, 2011, the Wake Substance Abuse Unit is planned to open. It will provide sixteen (16) beds for the voluntary treatment of substance use disorders.

Statewide Initiatives

Three-Way Hospital Beds. Since FY 2008, the General Assembly has appropriated funds, even in years of scarce resources, for the purpose of the purchase of inpatient psychiatric beds or bed days in communities around the State. The purpose of the purchase of these beds and bed days is several-fold:
(1) to provide individuals who need inpatient psychiatric care an opportunity to locate treatment nearer to their homes and allow better contact and family care, and;

(2) to reduce wait times in State facilities and allow the State hospitals to focus on treatment of persons with the most intensive needs;
(3) to reduce short-term admissions (7 days or less) to State Hospitals;
(4) to decrease emergency room (ED) wait times and impact on law enforcement;
(5) Stop the trend toward closure of inpatient beds.

A standardized contract is signed by DMH/DD/SAS, the LME in whose catchment area the hospital is located, and the hospital itself, hence the designation, "three-way hospital beds." The contract provides for a rate per night per bed which allows the hospital to recover its cost in the provision of the bed, including psychiatric care. It also allows participating hospitals to receive priority in transferring individuals with more intensive needs to State hospitals.

The expansion of these beds is accomplished in three (3) ways:
(1) Opening new beds (CON or State hospital transfer);
(2) Staffing unused capacity;
(3) Opening Existing Bed Capacity to Involuntary Commitments.

In FY2008-2009, contracts were initiated with
- Eleven Community Hospitals, and;
- Phased In throughout the year as increased capacity came on-line;
- Capacity was increased by 67 Beds;
- Participating hospitals served an additional 1,453 patients over FY 07-08 Actual Admissions.
- The State paid for 6,316 Days of Care through the 3-Way Hospital initiative.

The following chart represents the current (FY2011) configuration of contracted 3-way hospital beds across the State.

Table. FY2011 3-Way Contract Hospitals and Beds (as of October 27, 2010)

LME Name	Hospital Name	Number of Beds in SFY11 Contract	2011 Contract Amount	Contracted Units	SFY 11 Units to -Date
Mental Health Partners	Catawba Valley	12	3,285,000	4,380	694
Pathways	Kings Mountain	5	1,026,563	1,369	280
Alamance-Caswell	Alamance Regional	4	821,250	1,095	201
Sandhills	Moore Regional	9	2,394,000	3,192	383
Durham	Duke University Health	4	1,048,500	1,398	
Centerpoint	Forsyth Memorial	11	2,941,500	3,922	510
Cumberland	Cape Fear Valley Hosp.	5	1,026,563	1,369	93
Eastpointe	Duplin General	5	1,095,000	1,460	140
Beacon Center	Nash Hospitals (Coastal Plain)	11	2,941,500	3,922	477
ECBH	Beaufort Regional Medical	3	615,938	821	136
ECBH	Northside @ Roanoke-Chowan	5	1,368,750	1,825	345
Smoky Mountain	Haywood Regional	4	1,095,000	1,460	151
Smoky Mountain	Charles A. Cannon Memorial	3	821,250	1,095	118
Southeastern Center	The Oaks	8	2,120,250	2,827	471
Western Highlands	Margaret Pardee Memorial	4	821,250	1,095	144
Crossroads	Davis Regional Med. Cntr	5	1,026,562	1,369	
Guilford	Moses Cone Hospital	4	821,250	1,095	
Western Highlands	Mission Hospital	5	1,026,563	1,369	130
Western Highlands	Rutherford Hospital	3	615,938	821	69
ECBH	Pitt Memorial	3	460,688	614	
Mecklenburg	Presbyterian	8	1,503,000	2,004	
Totals		**121**	**28,876,315**	**38,502**	**4,342**

Housing

HUD 811 Housing. There are currently group homes and apartments with a total of 489 operational beds that have been developed with federal Housing and Urban Development (HUD) funds and HOME funds in the service area that will be affected by the closure of Dix. For example, the Sandhills' catchment area has developed more than 90 residential beds including 8 group homes and apartments in 10 locations. Since the mid-1980's, significant amounts of housing have been developed in North Carolina and been funded by HUD. The HUD Section 811 program makes capital advances to finance the development of rental housing and group homes with the availability of supportive services for persons with disabilities. The advance is interest free and does not have to be repaid as long as the housing remains available for very low-income persons with disabilities for at least 40 years. Project-based rental assistance covers the difference between the HUD-approved operating cost of the project and the tenants' contributions toward rent and utilities (usually 30 percent of monthly adjusted income) in the rental housing units.

HUD 811 projects have had significant funding cuts in recent years. In the latest funding round only one new 811 project was funded in all of North Carolina. Stakeholders should be aware that existing projects are extremely valuable and provide a solid housing option for persons with disabilities, but the State should not count on any new projects if current federal funding trends continue.

Oxford House. In the service area that will be affected by the closure of Dix, Oxford Houses currently have more than 500 beds. North Carolina State Oxford Houses are a clean and sober housing option for individuals in recovery. The first North Carolina Oxford Houses were established in Durham, NC and Asheville, NC in the spring of 1991. As of August 2010, there are 139 houses in North Carolina, with locations in 28 cities. With an average of 8 beds per house, there are more than 1,000 Oxford House beds in the State. Individuals typically enter an Oxford House after completing a drug and alcohol treatment program. Individuals living in a house are expected to participate in a recovery program in the community during their residence. All Oxford House residents are required to pay monthly rent and their percentage of all household utilities, averaging approximately $350 - $500 per month.

Targeting and Key Programs. As part of this housing initiative, independent supportive housing rental units statewide will be developed and targeted to serve persons with disabilities. The Key Program provides an operating subsidy in the form of rental assistance for persons with disabilities in targeted Low-Income Housing Tax Credit units. The Key Program originally was jointly funded by the NCHFA HOME Match funds and the Mental Health Trust Fund. As of September 1, 2010, the Targeting Program includes a total of 2,243 funded units, in over 340 properties, covering 141 cities, in 70 counties. Communities have additional sources of subsidized housing for which persons with disabilities are eligible to apply. There is active LME involvement in the catchment areas impacted by the closure of Dix.

Local Public Housing Authorities: Public Housing and Section 8 Public Housing are both available in most communities across the state, operated by local public housing authorities in direct relationship with the U.S. Department of *Housing and Urban Development.* Most public housing authorities also administer the Section 8 Voucher Program which provides rental assistance for use in the private sector. Most communities have closed Section 8 intake lists and/or have had extensive waiting lists for multiple years. Almost as many communities have lengthy waiting lists for public housing assistance. However, in the majority of communities, one bedroom units for persons with disabilities and the elderly are the public housing units that become available most often. Potential tenants should be encouraged to apply whenever those waiting lists are opened.

HUD McKinney-Vento Homeless Assistance Projects: McKinney-Vento funds are available for communities to request through establishing a homeless Continuum of Care (CoC). Thirteen CoCs exist in North Carolina and cover all 100 counties. These volunteer associations coordinate the application process for two types of HUD funding: Shelter Plus Care and Supportive Housing Program. If an application is successful, the contract for services is between HUD and a local unit of government or nonprofit that will provide the housing resource. Both programs specifically target homeless persons who have documented disabilities. A person who enters an institution with a homeless status and exits that institution within 7 days is considered homeless by HUD's definition. In addition, persons who have been institutionalized for over 30 days, are going to be released within 7 days, and have no alternative place to go, also meet HUD's definition of homeless and are eligible for housing provided by these programs. These funds are not controlled by the State.

Shelter Plus Care provides rental assistance, similar to the Section 8 Voucher Program. Shelter Plus Care is always operated by a unit of local government which may include housing authorities, county governments, or LMEs. There are over 1,030 Shelter Plus Care vouchers in 19 communities across North Carolina. The Supportive Housing Program is site based, and provides construction, renovation, and operating or leasing assistance for a property that will provide transitional or permanent supportive housing to homeless persons with disabilities. Some Supportive Housing Programs serve homeless families that do not have disabilities. There are over 80 funded Supportive Housing Program units in North Carolina.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services Monitoring of Wake and Sandhills Center. Monitoring of services and functions of the LMEs by DMH/DD/SAS is implemented in several ways:

Monitoring of Critical Indicators:
The LMEs submit regular reports to the DMH/DD/SAS Quality Management Team, and the team compiles LME scores for critical indicators of service performance. These results are then published in the quarterly Community Systems Progress Report. Examples of indicators include:

1. Timely Access to Care (Routine Care)
2. Timely Initiation and Engagement of Individuals in Service (Mental Health)
3. Effective Use of State Psychiatric Hospitals

4. State Psychiatric Hospital Readmissions
5. Timely Follow-Up Care for Individuals After Inpatient Care (ADATCs)
6. Timely Follow-Up Care for Individuals After Inpatient Care (Psychiatric Hospitals)

For these services, statewide averages and baseline data are identified, and LMEs are reviewed according to their performance in comparison to all other LMEs (statewide averages) and against baseline data and goals established for each indicator. The results of these reviews have several consequences. For those 17 of the 23 LMEs who receive their funding for services and supports in an aggregate and are allowed to use them with flexibility based on the needs of the LME (Single-Stream Funding), certain percentages are required to be maintained in order to be allowed to continue to receive funding in a single-stream. Statute requires DMH/DD/SAS to assure that LMEs are meeting standards for required LME functions. When these data suggest that an LME is functioning considerably lower than other LMEs, or when one or more are functioning considerably under statewide averages or established goals, DMH/DD/SAS is required to intervene to bring the LME to acceptable performance standards. If those standards are not met within identified timeframes, DMH/DD/SAS is required to take action such as removing functions, to assure individuals are appropriate served. The most recent report may be found under the heading "Community Systems Progress Reports,": http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Geographical Considerations

Central Regional Hospital is located approximately 36 miles north of Dorothea Dix Hospital. The table below lists counties and county seats currently served by DDH and compares their proximity to CRH and to DDH.

Distances in Miles from County Seat to DDH and CRH

County	County Seat	Distance in Miles from County Seat to DDH (2108 Umstead Drive, Raleigh)	Distance in Miles from County Seat to CRH (300 Veazey Road, Butner)	Additional Distance in Miles (one way) to CRH
Anson	Wadesboro	116	145	**29**
Harnett	Lillington	32	66	**34**
Hoke	Raeford	87	116	**29**
Lee	Sanford	40	69	**29**
Montgomery	Troy	86	117	**31**
Moore	Carthage	57	86	**29**
Randolph	Asheboro	70	92	**22**
Richmond	Rockingham	96	125	**29**
Wake	Raleigh	0	36	**36**
Average		*65*	*95*	***30***

Analysis of averages distances from county seats to the other two State hospitals shows the following:

The average distance from county seats served by Broughton Hospital to Broughton Hospital is 73 miles. The average distance from county seats served by Cherry Hospital to Cherry Hospital is 91 miles. Once Wake and Sandhills LMEs admit to CRH, the average distance from county seats served by CRH to CRH will be 70 miles.

Additionally, of the counties served by Broughton Hospital, the most distant county seat from Broughton is Murphy in Cherokee County, 166 miles away. Of the counties served by Cherry Hospital, the most distant county seat from Cherry is Manteo in Dare County, 186 miles away.

Comparing another large metropolitan area, Charlotte, to Raleigh, reveals that Charlotte is 74 miles from Broughton Hospital; twice the distance Raleigh is from CRH.

The 30 additional miles, on average, it will take for law enforcement officers to patients to CRH, is not ideal, but reasonable, given the large geographic area covered by North Carolina and the fact that North Carolina is served by three State Hospitals strategically located across the State.

IV. Conclusion

Dorothea Dix Hospital has a long and proud history of service to North Carolinians who require inpatient psychiatric hospitalization. Although forced by a significant budget deficit to implement cost reduction measures and, ultimately close Dorothea Dix Hospital, the Department of Health and Human Services has effected the changes while working to ensure the safety, care and treatment of current patients, preserving employment opportunities for Dix staff and, without reducing State hospital bed capacity, actually increasing beds at Broughton Hospital. The on-going stabilization and expansion of community-based services in Wake and Sandhills Center LMEs will provide more comprehensive mental health services to individuals locally, requiring fewer referrals to Central Regional Hospital.